WASATCH CITY-COUNTY BOARD OF HEALTH APRIL 15, 1985

Conducting: Connie Tatton

Welcome: (Excuse Cal & Maxine)

Invocation:

Approval of Minutes:

1) Alcohol & Drug Report: Robert Blanthorn

2) Contracts: Phil Wright

Approved

- Immunization- $1,500 same for 4 yrs $2700
- WIC- Food $28,573 Total Food 94,776
  Adm $ 9,791 Total Adm 38,754
- School- $ 9,765 — approved —

Special MCH — Maternal Child Health
- Prenatal care
- Dental care
- Pregnancy testing

} Due yet.

3) New Building Status: Phil

- Sewer system
- Annexation into Heber City
- Telephone system — Merlin System New

4) Senior Citizens Physical Exam Screening: Phil

- Authorized-72
- Complete-21

5) Kindergarten Registration: Maren

Complete- 230
Remaining- 70

6) WIC Report: 282 clients (March) Phil

7) Blood Pressure Checks: 35 (March) 28 were senior citizens

8) Immunization Report: 113 (March)

9) New Projects Proposal: Phil
- Clift Jordon — change Zoning
- Frances Smith
- Rec Vehicle Park — Boggess
- Snake Creek Property owners

10) Food Service Survey: Phil

Other:

15 Apr 1985

MINUTES OF THE WASATCH CITY-COUNTY BOARD OF HEALTH

April 15, 1985 12:05 P.M. Health Office

Present were:	Connie Tatton	Vice-chairman
	Elizabeth Murdock	Member
	Rulon Phillips	Member
	R. Raymond Green	Medical Officer
	R.C. Tadd	Commissioner
	Phil Wright	Health Officer
	Robert Blanthorn	Alcohol/Drug Director
	Ranae Williams	Nutritionist/Educator
	Nelda Duke	Secretary
Excused:	Calvin Giles	
	Maxine McAffee	

Welcome: Mrs. Tatton welcomed those present and called the meeting to order.

Invocation: The invocation was offered by Commissioner Tadd.

Minutes: Minutes of the meeting held March 18, 1985, were read by Mrs. Duke. Mrs. Murdock made a motion minutes be approved as read. Mr. Phillips seconded the motion. Motion carried.

Alcohol/Drug Report: Mr. Blanthorn reported they now have 11 clients in their program as well as 24 high school students in the prevention program. Training of teachers will begin on April 30th for two or three days.
Commissioner Tadd submitted two bills to Mr. Blanthorn for services rendered from the TCMHC. Apparently we do not have a contract with TCMHC for treatment for alcohol and drug problems. These clients must be sent to Utah County. Mr. Blanthorn will check on this problem.

Contracts: Mr. Wright discussed the following contracts:

1) Immunization $1500
2) WIC Amendment
   Food $28,573 Total Food 94,776
   Adm 9,791 Total Adm 38,754
3) School 9,765
4) Special MCH
   The MCH contract will include prenatal care this year. There was some discussion as to what services we could offer under this contract. It was suggested we offer some dental care, pregnancy testing, etc.

Mrs. Murdock made a motion we accept these contracts as noted and ask for an increase in our immunization contract. Dr.Green seconded motion. Motion carried.

Pediatric Nutrition Course:	Mr. Wright stated Mrs. Williams has been selected from the state to attend a Pediatric Nutrition Intensive Course at the Iowa University in May. Expenses will be paid by the State WIC Program through a special contract.
New Building Status:	Mr. Wright reported the new building is progressing on schedule. The sewer system is being installed and we are annexed into Heber City. The board discussed the telephone system and felt we should sell our existing system to the highway patrol and buy a new system to cover all our needs in the new building.
Senior Citizens Health Screening:	Mr. Wright reported we have authorized 72 health screening exams for senior citizens. Twenty one physicals have been completed. Dr. Green stated he had found several patients with health problems in doing senior citizens physical exams. He felt this is a very worth while project.
Kindergarten Registration:	It was reported we have cleared approximately 200 children for kindergarten registration. We expect to have 25 to 30 more children in for registration clearance.
WIC Report:	Mrs. Williams reported we now have 282 clients on our WIC program.
Blood Pressure Checks:	There were 35 blood pressure checks given last month. Twenty eight of those were senior citizens. It was suggested we set up clinics throughout the county and perhaps in the high school to check young people's blood pressure.
Immunization Clinics:	It was reported we gave 113 immunizations last month. Also immunization clinics have been set up for the first and third Thursday of each month. The first clinic will be held from 9 to 1 PM and the second clinic will be held from 5 to 7 PM.
New Project Proposals:	Mr. Wright reported on new projects being proposed in the county: 1) Clift Jordan R.V. Park 2) Jack Boggess R.V. Park 3) Snake Creek Property Owners enlargement of water system for new hook-ups
Strawberry Lake Estates:	It was reported Strawberry Lake Estates is still having problems getting water rights.
Food Service Survey:	Mr. Wright stated he will be working on the Food Service Survey this month.
Next Meeting:	The next meeting is scheduled for Monday, May 20th 12:00 noon in the health office.

_____
Vice-chairman

WASATCH CITY-COUNTY HEALTH DEPARTMENT

55 WEST CENTER
HEBER CITY, UTAH 84032
PHONE 654-2700

Date_____

Dear Dr._____,

The Wasatch City-County Health Department has authorized _____to have a health screening physical exam at your office. Please bill the health department for this service.

Thank You,

Phil D. Wright

Phil D. Wright, M.S.,R.S.
Health Officer

UTAH DEPARTMENT OF HEALTH
DIVISION OF COMMUNITY HEALTH SERVICES
BUREAU OF EPIDEMIOLOGY

Suzanne Dandoy, M.D., M.P.H.
Executive Director

COMMUNICABLE DISEASE NEWSLETTER

Adele P. Nelson, R.N., M.P.H., Director
Division of Community Health Services

EDITOR: Craig R. Nichols, M.P.A., State Epidemiologist
Director, Bureau of Epidemiology
(801) 533-6191

MONTH May YEAR 1985

CONTENTS

MEASLES FREE

No cases of measles (rubeola) have been confirmed in Utah since April 12, 1984. During the last five years (1980-1984) only 96 cases have occurred, compared to 2,812 reported between 1975-1979.

In spite of these encouraging statistics, there are ample reasons for avoiding complacency. The Immunization Survey of Utah Two-Year-Olds conducted in late 1984 revealed a decline in the proportion of those adequately immunized against measles compared to the 1980 survey results (89.0% vs. 80.9%). Additionally, 22 states throughout the country are currently reporting measles; the majority of cases reported in 1985 have occurred in college-age individuals, many of whom have escaped school immunization efforts.

The immunization levels in Utah are not high enough to preclude the possibility of secondary spread in the event of an imported case of measles. All health professionals are encouraged to remain vigilant against the threat of measles and to report any rash illness compatible with measles infection.

PREVENTION AND CONTROL OF INFLUENZA

The Immunization Practices Advisory Committee (ACIP) has released the recommendations for the use of the vaccine and antiviral agent available for the control of influenza. These recommendations, reported in the May 17, 1985 edition of Morbidity and Mortality Weekly Report (Vol. 34/No. 19) are generally similar to recommendations made last year, with the following notations.*

1. "Based on the most recent epidemiologic and laboratory data, it is anticipated that the strains prevalent in 1985-1986 will be closely related to A/Philippines/2/82 (H3N2), A/Chile/1/83 (H1N1), and B/USSR/100/83. Although the components and their concentration in the 1985-1986 influenza vaccine will be identical to the 1984-1985 vaccine, all 1984-1985 influenza vaccines released for civilian use have a June 30, 1985 expiration date. Remaining 1984-1985 vaccines should not be used beyond their expiration dates.

2. "Data on influenza vaccine immunogenicity and reactogenicity have generally been obtained when vaccine is administered by the intramuscular (deltoid) route. Because adequate evaluation of other routes in high-risk groups is lacking, the preferred route of vaccination is the deltoid muscle whenever possible.

3. "To reduce disruption of medical care and to reduce the spread of virus to high-risk persons when influenza A virus outbreaks occur, amantadine hydrochloride prophylaxis is desirable for those physicians, nurses, and other personnel who have extensive contact with high-risk patients but failed to receive the recommended annual influenza vaccination before the onset of influenza A activity. Such unprotected health-care workers should be immediately offered vaccine and provided amantadine for the subsequent 2 weeks while a protective response to vaccination develops. If vaccine is not given, is unavailable, or is of low efficacy due to a major antigenic change in the virus, amantadine prophylaxis should be continued throughout the period of influenza A activity in the community. Other health-care workers in hospitals should also be offered amantadine as long as this does not jeopardize the availability of the drug for prophylaxis of staff having greatest contact with high-risk patients.

4. "The usual dose of amantadine is 200 mg per day. Splitting the dose into 100 mg twice daily may reduce the frequency of side effects. Because renal function normally declines with age and because side effects have been reported more frequently in older persons, a reduced dosage of 100 mg/day is generally advisable for persons 65 years and older to minimize the risk of toxicity. (Dosages for children and for persons of any age with recognized renal disease are given in the original report.) Persons 10-64 years old without recognized renal disease but with an active seizure disorder may also be at risk of increased frequency of their seizures when given amantadine at 200 mg/day rather than 100 mg/day."

* A copy of the complete recommendations is available upon request from the Bureau of Epidemiology.

INOCULATION OF SELECTIVE MEDIUM CULTURE PLATES - GONORRHEA

In a quality assurance review, recently conducted in Utah by the Centers for Disease Control, it was noted that the method of inoculating selective medium culture plates for gonorrhea was only "partially satisfactory" in that "a number of plates received were poorly inoculated and cross-streaked". In an effort to standardize inoculation procedures and to maximize interpretation of culture results, the following information may be useful to health professionals. It is adapted from the "Guide for the Diagnosis of Gonorrhea Using Culture and Gram Stained Smear" published in January, 1985, by the Centers for Disease Control. A copy of the Guide, which also provides diagnostic indications, techniques, and criteria, is available upon request from the Bureau of Epidemiology.

1. "For screening purposes, acceptable results may be obtained from inoculation of a single divided plate of selective medium with two specimens from the same site (e.g., endocervix) or with specimens from the endocervix and the rectum. Data suggest that dual specimens from one site may improve detection and that the dual-plating technique may offer economic advantages and acceptable results when the patient to be screened has been exposed at both the endocervix and rectum. A divided plate is not recommended for test-of-cure, however. Data indicate that this procedure is less sensitive than using separate plates with patients who are positive only at the rectum on test-of-cure.

2. "Roll swab in a large "Z" pattern on a 100 mm plate containing selective medium. Cross-streak immediately with a sterile wire loop or the wooden end of a second sterile swab in the clinical facility.

3. "An alternative procedure is to roll the swab over a 20-25% segment of the medium surface. Cross-streak the media using the standard microbiological procedure for colony separation.

4. "When inoculating a divided plate with specimens from separate sites, identify the sites by using different procedures to roll each swab so the laboratory can accurately report the infected site if only one side of the plate is positive."

MENINGOCOCCAL DISEASE IN NEW DELHI, INDIA[1]

"Between January 1 and March 30, 1985, 2924 cases of meningococcal disease in New Delhi have been reported to the National Institute of Communicable Disease in India. This area had experienced little meningococcal disease previously. Three hundred and twenty-seven of the cases have been fatal. It is not known how many of the cases are culture-confirmed. A few isolates of *N. meningitidis* have been available for study - all have been serogroup A. Reliable attack rates are not available, but the reported number of cases suggests that a major epidemic is occurring. To date, no other areas of India are known to be experiencing a similar outbreak. Recent epidemic group A meningococcal disease in this part of the world first occurred in the Kathmandu Valley of Nepal, beginning in early 1983, and continuing at much lower levels in 1985.

"No cases in New Delhi are known to have occurred in travelers or in the expatriate community. The risk of disease in travelers is likely to be low. However, because the number of cases is substantially above that seen previously in this area, it is prudent for travelers planning to stay in New Delhi to be vaccinated before leaving the United States.

"The serogroup A meningococcal vaccine has a clinical efficacy of 85-95% for at least one year, with protection being achieved 1-2 weeks following vaccination. Adverse reactions are limited to local erythema or soreness. There are 2 formulations of meningococcal vaccine currently available in the United States: the bivalent A-C vaccine and the quadrivalent A,C,Y,W-135 vaccine. Either formulation will give protection against serogroup A

meningococcal disease; the bivalent vaccine is less expensive. The sole distributor of these vaccines in the United States is Squibb. The vaccine can be obtained through a pharmacy by contacting a Squibb regional distribution center or by calling Squibb at 1-800-VACCINE.

"All recipient health departments, travel agencies, airlines, and shipping companies are requested to notify prospective travelers of these recommendations."

Reference

1. Centers for Disease Control, Center for Preventive Services, Advisory Memorandum No. 79, April 17, 1985.

PREVENTION OF COLORADO TICK FEVER

With the upcoming warm months of summer, Utahns will undoubtedly be spending more time in the forests and campgrounds of Utah. Those areas of natural beauty are also the habitat of Dermacentor andersoni, the Rocky Mountain wood tick. This arthropod is well known in Utah and surrounding states as a vector in the transmission of Colorado tick fever (CTF).

Colorado tick fever is a viral disease of short duration, characterized by sudden onset, recurrent fever, headache or muscular pain, and leukopenia (reduction of white corpuscles in the blood). CTF is common in Utah; during the past five years (1980-1984), 223 cases were reported. Treatment of clinical cases is symptomatic. Because there is no vaccine for protection against CTF, prevention depends primarily on avoidance of tick bites. The following preventive measures are recommended when participating in outdoor activities where ticks are present.

1. Wear protective clothing, especially long-sleeved shirts and long pants when feasible.

2. Conduct a daily body inspection, with prompt removal of all ticks from body and clothing. Children should be thoroughly examined by an adult. Special attention should be given to body areas covered with hair.

3. Use insect repellents. Those containing diethyl toluamide (deet) are generally most effective. The application of repellent to exposed skin provides little protection against ticks since they may crawl underneath clothing and attach onto untreated portions of the body. The application of repellent to the entire body may be useful for a few hours, but such extensive applications may not be practical and may be injurious.

4. Leave pets at home as they can carry ticks to humans.

5. Consult a physician if any of the symptoms of CTF occur.

Reference

1. Centers for Disease Control, Vectorborne Disease Control, Course 3013; 1983.

MINUTES OF THE WASATCH CITY-COUNTY BOARD OF HEALTH

May 20, 1985 — 12:10 PM — Health Offices

Present were:	Calvin Giles	Chairman
	Connie Tatton	Vice-chairman
	Elizabeth Murdock	Member
	Rulon Phillips	Member
	R.C. Tadd	Commissioner
	R. Raymond Green	Medical Officer
	Phil Wright	Health Officer
	Maxine McAffee	Nurse Supervisor
	Ranae Williams	Educator/Nutritionist
	Robert Blanthorn	Alcohol/Drug Director
	Nelda Duke	Secretary

Welcome: Mr. Giles welcomed those present and called the meeting to order.

Invocation: Mrs. McAffee gave the invocation.

Approval of Minutes: Minutes of the meeting held April 15, 1985 were read by Mrs. Duke. Mrs. Murdock make a motion minutes be corrected and approved. Mrs. Tatton seconded motion. Motion carried.

Alcohol/Drug Report: Mr. Blanthorn reported they now have 14 clients receiving services from their program. The high school groups and the K thru 12 training is completed. The county has paid for two scholarships and Mrs. Beverly Prince and Ray Neilson will use them to attend a program for alcohol and drug abuse at the University of Utah.

He also reported they are planning activities for high school graduation. They will be distributing buttons which read, "Its OK not to drink", along with other activities.

30
4/12

Senior Citizens Physical Exams: It was reported we had issued 112 requests for senior citizens physical exams. These must be completed by the end of June. Dr. Green suggested we do some calling to senior citizens who perhaps do not have access to the local paper to let them know of this service. Commissioner Tadd will have his secretary get a roster and call citizens regarding this program. It was also suggested we have the doctors give us a report as to the findings of this program.

Contracts: Special MCH: Mr. Wright stated we have a special MCH contract that has been signed and returned to the state. We will use this for educational supplies.

Occupant Protection: We also have an occupant protection contract for the purchase of car seats and educational material. It was suggested we buy health related video tapes to play to

clients while they are waiting for services.

Immunization Clinics: Mrs. McAffee reported the evening immunization clinics are going very well. She gave 55 immunizations as compared to the last morning clinic of 35 immunizations.

WIC: Mrs. Williams reported we now have 271 clients receiving services through the WIC program. We will have a state audit in June. We asked for comments from WIC clients regarding the WIC program and received many favorable comments. any bad reports

Hypertension: Mrs. McAffee reported she had tested 44 clients for blood pressure during our monthly clinic. Mrs. Williams done some educational counseling which was very well received during this clinic.

New Building: Mr. Wright stated the new building is coming along on schedule. They are now painting and the carpet bids have been let. The county is doing the leveling and grading of the parking lot and the telephone system has been ordered.

Jordan Ranch Proposal: Mr. Wright submitted plans for the Jordan Ranch RV and Mobile Home Park. Most test holes have a high water table. There was some discussion on this proposal.

Boggess Ranch RV Park: Mr. Wright stated the Boggess Ranch RV Park also has high ground water.

Mayflower Mountain: Mr. Wright submitted plans for the Mayflower Mountain Development. There was some discussion on this project.

Woodland Estates: Mr. Wright stated he had received a complaint on a lot in Woodland Estates. He gave a clean up order and will have them install a septic tank and drainfield.

Food Survey: Mr. Wright stated he had completed the Food Survey and it looks like an improvement from previous years. He also stated the Homestead has problems again.

Mortgage File Search: Mr. Wright stated we receive many requests from mortgage companies and banks for file searches for septic tank inspections and approvals. After some discussion Dr. Green made a motion we charge a $20 minimum search fee plus $10 for each additional hour. Mrs. Tatton seconded motion. Motion carried.

Strawberry Lake Estates: Commissioner Tadd stated that Duchesne will lease water to Strawberry Lake Estates on a 20 year lease with the right to take it back. This is unacceptable to our county so Mr. Mahoney will continue to work on this water problem.

Keetley Water:	Mr. Wright stated two water samples have been submitted and satisfactory for the Keetly water system. The license for the Longbranch Cafe is due in July and they will have to correct some problems before a license will be issued.
Soldier Summit Bar:	Mr. Wright stated Soldier Summit wants to re-open their bar. They need to have work done on their sewage disposal system.
Charleston Water:	Mr. Wright stated the Charleston water system has good samples as long as they are not pumping from their spring. Most other water systems in the county have submitted good samples during the winter months.
Wallsburg Complaint:	Mr. Wright sent a letter to Mr. Mecham in Wallsburg concerning a complaint of dead animals near and in a stream. He will follow-up on this problem.
Holmes Manure Pit:	It was reported that the manure pit at the Holmes Dairy was overflowing into Lake Creek.
Annual Morbidity Summary:	Mr. Wright submitted a copy of the "Annual Morbidity Summary". (See copy #1).
Next Meeting:	The next meeting was scheduled for Monday, June 17th 12:00 noon in the Health Offices.
Adjournment:	Meeting was adjourned at 1:30 P.M.

_____
Chairman

UTAH DEPARTMENT OF HEALTH
DIVISION OF COMMUNITY HEALTH SERVICES
BUREAU OF EPIDEMIOLOGY

Suzanne Dandoy, M.D., M.P.H.
Executive Director

COMMUNICABLE DISEASE NEWSLETTER

Adele P. Nelson, R.N., M.P.H., Director
Division of Community Health Services

EDITOR: Craig R. Nichols, M.P.A., State Epidemiologist
Director, Bureau of Epidemiology
(801) 533-6191

MONTH June YEAR 1985

CONTENTS

HTLV-III TESTING AND COUNSELING

Alternate testing centers have been established at local health departments throughout Utah to provide screening for antibody to human T-lymphotropic virus type III (HTLV-III). HTLV-III has been recognized as the cause of acquired immunodeficiency syndrome (AIDS).

Personnel at all of the centers have been trained to provide pre- and post-testing counseling to persons being tested. Individuals desiring testing will be notified that the HTLV-III test cannot be used to diagnose AIDS. The test will identify antibodies to HTLV-III, but is not a test to detect the virus itself. The primary purpose of the test is to screen donated blood to determine if the donor has been exposed to HTLV-III or a related virus.

High-risk individuals and persons requesting tests are encouraged to obtain testing through the alternative test sites rather than using blood donation as a method of obtaining screening. Testing sites will provide all services either at no cost or after payment of a nominal fee. No one will be refused services because of inability to pay.

Individuals desiring testing should be aware that a positive antibody test result can have a significant psychological impact on both the person tested and those who are close to him or her. At the present time, the consequences for persons who are infected with HTLV-III are unpredictable since no treatment is currently available for the infection. It has also been suggested by some that insurance companies or employers may seek information about positive test results as a condition of coverage or employment.

Listed below are the alternative testing sites in Utah. Details regarding clinic hours and locations can be obtained by telephoning the desired center.

ALTERNATE TESTING AND COUNSELING SITES
FOR
HTLV-III

Bear River District Health Department	
Logan	752-3730
Central District Health Department	
Nephi	623-0696
Delta	864-3612
Richfield	896-4541
Loa	425-3497
Ephraim	283-4021, Ext. 385
Southeastern District Health Department	
Price	637-3671
Castle Dale	381-2252
Moab	259-5602
Monticello	587-2021
Southwest District Health Department	
St. George	673-3528
Cedar City	586-2437
Uintah Basin District Health Department	
Vernal	789-1264
Weber-Morgan District Health Department	
Ogden	399-8436
Davis County Health Department	
Farmington	451-3340
Salt Lake City-County Health Department	
Salt Lake City	530-7666
Summit City-County Health Department	
Park City Clinic	649-5989
Coalville	336-4451
Tooele County Health Department	
Tooele	882-5550
City-County Health Department of Utah County	
Provo	375-8100
Wasatch City-County Health Department	
Heber City	654-2700

HEMOPHILIA AND HTLV-III

The Centers for Disease Control, the Health Resources and Services Administration and the National Hemophilia Foundation are recommending that all persons with hemophilia who wish to be tested for HTLV-III antibody be referred to the existing network of comprehensive hemophilia treatment centers. The treatment centers or a patient's private physician are the preferred entry points for patients desiring more information about HTLV-III testing and hemophilia. After initial counseling, persons with hemophilia may be referred to public alternate testing sites.

Comprehensive hemophilia treatment centers in Utah are located at the University of Utah College of Medicine (581-7914), Primary Children's Medical Center (521-1221), and National Hemophilia Foundation, Utah Chapter (363-3024)

MULTIPLE-ANTIBIOTIC RESISTANT STREPTOCOCCUS PNEUMONIA[1]

Streptococcus pneumoniae, type 23F, resistant to several antibiotics was isolated from both blood and spinal fluid taken from a Duchesne County child with meningitis. The organism was resistant to penicillin, chloramphenicol, gentamicin and tetracycline, but was sensitive to rifampin and vancomycin.

Penicillin-resistant pneumococci appeared in 1967. Since then, relatively resistant and resistant strains have been reported from many parts of the world. The prevalence of relative resistance reported in clinical isolates has varied from 1% to as high as 16%, but most studies show a prevalence of approximately 2%.

In 1977, multiply resistant pneumococci was first reported in South Africa, and since then have been recognized in the United Kingdom, Australia, New Guinea, and the United States. This recent case of penicillin-resistant pneumococci and other reports describing relative penicillin resistance in the United States emphasize the need to screen all clinically significant pneumococcal isolates for penicillin sensitivity using a 1 μg oxacillin disc. Those isolates having a zone size of $\leq$19 mm might be associated with infections that could respond poorly to penicillin therapy and should be tested for penicillin resistance using a broth-dilution technique; these isolates should also be screened for resistance to other antibiotics. Isolates found to have high-level resistance ($\geq$1 μg) to penicillin, or multiple antibiotic resistance, should be saved and reported to the Bureau of Epidemiology.

Reference

1. Adapted from Centers for Disease Control, Morbidity and Mortality Weekly Report, Vol. 30/No. 17, May 8, 1981.

RHEUMATIC FEVER REPORTING REQUESTED

During 1984, Colorado reported an increase in reported rheumatic fever cases during spring and early summer. This year in Utah, an increase of rheumatic fever cases has been seen in at least one pediatric practice. In order to determine the incidence rate of disease, the Bureau of Epidemiology is requesting that all cases of rheumatic fever be reported utilizing existing morbidity report cards. Cards are available from local health departments.

Revision of the Case Definition of Acquired Immunodeficiency Syndrome for National Reporting—United States[1]

Patients with illnesses that, in retrospect, were manifestations of acquired immunodeficiency syndrome (AIDS) were first described in the summer of 1981 (*1,2*). A case definition of AIDS for national reporting was first published in the *MMWR* in September 1982 (*3,4*). Since then, the definition has undergone minor revisions in the list of diseases used as indicators of underlying cellular immunodeficiency (*5-8*).

Since the 1982 definition was published, human T-cell lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV) has been recognized as the cause of AIDS. The clinical manifestations of HTLV-III/LAV infection may be directly attributable to infection with this virus or the result of secondary conditions occurring as a consequence of immune dysfunction caused by the underlying infection with HTLV-III/LAV. The range of manifestations may include none, nonspecific signs and symptoms of illness, autoimmune and neurologic disorders, a variety of opportunistic infections, and several types of malignancy. AIDS was defined for national reporting before its etiology was known and has encompassed only certain secondary conditions that reliably reflected the presence of a severe immune dysfunction. Current laboratory tests to detect HTLV-III/LAV antibody make it possible to include additional serious conditions in the syndrome, as well as to further improve the specificity of the definition used for reporting cases.

The current case definition of AIDS has provided useful data on disease trends, because it is precise, consistently interpreted, and highly specific. Other manifestations of HTLV-III/LAV infections than those currently proposed to be reported are less specific and less likely to be consistently reported nationally. Milder disease associated with HTLV-III/LAV infections and asymptomatic infections may be reportable in some states and cities but will not be nationally reportable. Because persons with less specific or milder manifestations of HTLV-III/LAV infection may be important in transmitting the virus, estimates of the number of such persons are of value. These estimates can be obtained through epidemiologic studies or special surveys in specific populations.

Issues related to the case definition of AIDS were discussed by the Conference of State and Territorial Epidemiologists (CSTE) at its annual meeting in Madison, Wisconsin, June 2-5, 1985. The CSTE approved the following resolutions:

1. that the case definition of AIDS used for national reporting continue to include only the more severe manifestations of HTLV-III/LAV infection; and
2. that CDC develop more inclusive definitions and classifications of HTLV-III/LAV infection for diagnosis, treatment, and prevention, as well as for epidemiologic studies and special surveys; and
3. that the following refinements be adopted in the case definition of AIDS used for national reporting:
   a. In the absence of the opportunistic diseases required by the current case definition, any of the following diseases will be considered indicative of AIDS if the patient has a positive serologic or virologic test for HTLV-III/LAV:
      (1) disseminated histoplasmosis (not confined to lungs or lymph nodes), diagnosed by culture, histology, or antigen detection;
      (2) isosporiasis, causing chronic diarrhea (over 1 month), diagnosed by histology or stool microscopy;
      (3) bronchial or pulmonary candidiasis, diagnosed by microscopy or by presence of characteristic white plaques grossly on the bronchial mucosa (not by culture alone);
      (4) non-Hodgkin's lymphoma of high-grade pathologic type (diffuse, undifferentiated) and of B-cell or unknown immunologic phenotype, diagnosed by biopsy;
      (5) histologically confirmed Kaposi's sarcoma in patients who are 60 years old or older when diagnosed.
   b. In the absence of the opportunistic diseases required by the current case definition, a histologically confirmed diagnosis of chronic lymphoid interstitial pneumonitis in a child (under 13 years of age) will be considered indicative of AIDS unless test(s) for HTLV-III/LAV are negative.
   c. Patients who have a lymphoreticular malignancy diagnosed more than 3 months after the diagnosis of an opportunistic disease used as a marker for AIDS will no longer be excluded as AIDS cases.
   d. To increase the specificity of the case definition, patients will be excluded as AIDS cases if they have a negative result on testing for serum antibody to HTLV-III/LAV, have no other type of HTLV-III/LAV test with a positive result, and do not have a low number of T-helper lymphocytes or a low ratio of T-helper to T-suppressor lymphocytes. In the absence of test results, patients satisfying all other criteria in the definition will continue to be included.

CDC will immediately adopt the above amendments to the case definition of AIDS for national reporting. This revision in the case definition will result in the reclassification of less than 1% of cases previously reported to CDC. The number of additional new cases reportable as a result of the revision is expected to be small. Cases included under the revised definition will be distinguishable from cases included under the old definition so as to provide a consistent basis for interpretation of trends. CDC will also develop draft classifications for disease manifestations of HTLV-III/LAV infections other than AIDS, distribute these widely for comment, and publish the results.

Reported by Conference of State and Territorial Epidemiologists; AIDS Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.

Reference

1 Centers for Disease Control, Morbidity and Mortality Weekly Report, Vol. 34/No. 25, June 28, 1985.

MONTHLY MORBIDITY SUMMARY

UTAH DEPARTMENT OF HEALTH
SELECTED REPORTABLE DISEASES

APPROVAL #8000008
APPROPRIATION #2870-A33010

PROVISIONAL DATA

Month JUNE 1985

County	Estimated Population 19 84	Colorado Tick Fever	Gonorrhea	Hepatitis (A, Non-A, Non-B, & Unspecified)	Hepatitis B	Influenza	Meningitis (Bacterial)	Meningitis (Non-bacterial)	Meningococcal Infections	Pertiacosis	Rabies (Animal)	Rubella	Rubeola	Salmonellosis	Shigellosis	Syphilis (less than 1 year duration)	Tuberculosis (New Active & Relapse)	Tularemia
Beaver	5,100																	
Box Elder	35,500		1											2				
Cache	65,000		2				1							1				
Carbon	23,400																	
Daggett	750																	
Davis	165,000	1	12	2	2	3	2											
Duchesne	14,600						1											
Emery	12,400																	
Garfield	3,950																	
Grand	7,600			1														
Iron	19,000																	
Juab	6,050																	
Kane	4,500																	
Millard	13,500																	
Morgan	5,300																	
Piute	1,500																	
Rich	2,150																	
Salt Lake	675,000	2	59	9	11	7	5	1						5	4	2		
San Juan	12,600		6	1										1				
Sanpete	16,800			1														
Sevier	15,900																	
Summit	12,000	1			1									2				
Tooele	28,100	1																
Uintah	24,200			1														
Utah	245,000			2			2											
Wasatch	9,200													1				
Washington	32,300		1												1			
Wayne	2,100																	
Weber	154,500		18	4	1		1							3				
Utah State Total	1,613,000	5	99	21	15	10	12	1	0	0	0	0	0	15	5	2	0	0
This Mo. Last Yr.	JUNE 1984	5	69	41	3	53	7	3	0	1	0	1	0	8	8	4	3	0
This Yr.To Date		5	555	180	88	1960	58	19	7	0	0	0	0	48	46	7	6	2
Last Yr.To Date		5	624	233	47	2819	47	13	4	1	0	7	27	50	38	19	19	2

Other Diseases: ASCARIASIS - 1, CAMPYLOBACTER - 6, FOODBORNE BOTULISM - 1, ENCEPHALITIS - 2, GIARDIASIS - 13, KAWASAKI DISEASE - 2, LEGIONELLOSIS - 1, LEPROSY - 1, MALARIA - 1, PERTUSSIS - 2, RHEUMATIC FEVER - 1

AIDS CUMULATIVE TOTAL - 4 TOXIC SHOCK SYNDROME 1985 CUMULATIVE TOTAL - 1

WASATCH CITY/COUNTY BOARD OF HEALTH

AGENDA

Recd 6-17-85

For 6-20-85

✓ Welcome:

✓ Invocation:

✓ Approval of Minutes:

✓ Alcohol & Drug Report: (Excuse Mr. Blanthorn) 14 Pathy Tucker 1/2 time

✓ WIC Report: 261

✓ Hypertension Report: 90 + health Fair

✓ Immunization Report: 90

✓ Health Fair: 108 73 Bld Tests 60 Both

✓ Giardia Investigation: Dr Kelly — infant

✓ Contracts:

✓ Pre-natal

✓ MCH Maternal Child Health

✓ Longbranch: Closed. Bud Bandy Apt house — Rixey

✓ Soldier Summit:

✓ Jordan Ranch: — Hi water

✓ Dr. Dandoy Site Visit: Snake Creek water

Other:

MINUTES OF THE WASATCH CITY/COUNTY BOARD OF HEALTH

June 21, 1985 | 12:05 P.M. | Health Offices

Present were:	Connie Tatton	Vice Chairman
	R. Raymond Green, M.D.	Medical Officer
	R. C. Tadd	Commissioner
	Phil D. Wright, R.S.,M.S.	Health Officer
	Maren Durtschi, R.N.	Nurse
	Nelda Duke	Secretary
Excused:	Calvin Giles	
	Elizabeth Murdock	
	Maxine McAffee	
	Robert Blanthorn	

Welcome: Mrs. Tatton welcomed those present and called the meeting to order.

Invocation: The invocation was offered by Mr. Wright.

Approval of Minutes: Minutes of the meeting held May 20, 1985, were read by Mrs. Duke. Dr. Green made a motion minutes be approved. Mr. Tadd seconded the motion. Motion carried.

Alcohol/ Drug Report: Mr. Wright stated the Alcohol/Drug program had a state site visit recently. He also reported they had hired Patti Tucker as their new part-time secretary.

WIC Report: Mrs. Durtschi reported we now have 261 clients receiving WIC benefits. Dr. Green said those working on the WIC program should be complimented for seeking out those who are in need of their services and for running an excellent program. It was mentioned from the 40 comments we received concerning services...all were positive.

Senior Citizen Exams: It was reported that we have issued approximately 150 consents to senior citizens for physical exams. Dr. Green asked if the monies was available for blood tests for those who are in need. Mr. Wright said there were enough monies for blood tests. Dr. Green suggested we ask clients if they have had a blood test recently, if not we could offer this service along with the physical exam.

It was also mentioned that these monies will run out the end of June and we need to start looking ahead to services that could be offered next year.

Hypertension: Mrs. Durtschi reported there was 30 blood pressures checked last month.

Immunization:	Mrs. Durtschi also reported we had given 90 immunizations last month.
Health Fair:	Mrs. Durtschi reported the Health Fair was a great success. 108 people attended. Thirteen had the 24 channel and thyroid test and 60 received the cardiac profile test. Those attending seemed to be impressed with the tests and health booths that were set up.
Giardia:	Mr. Wright stated Dr. Kelly called him and reported a case of Giardia in an 18 month old child who lived in a trailer park. Tests revealed that the mother also had the disease. Mr. Wright did some investigation and had water tested.
Contracts:	Mr. Wright stated we now have our 1985-86 contract for Child Health services. This will include dental, vision and audio services and will be based on a sliding fee scale. Mr. Wright also stated we have received a Maternal Health contract for $7,000.
Infant Mortality Study:	Dr. Green asked how the Infant Mortality Study was progressing. Mr. Wright said Dr. Ferguson was checking with BYU students who are working on this project. We will ask for a report from them soon as monies will run out the end of June.
Keetley Sewage Problem:	Mr. Wright stated the Long Branch and old school at Keetley are trying to rectify their sewage problems.
Soldier Summit Bar:	Mr. Wright stated the bar at Soldier Summit wants to re-open. They have sewage problems that will have to be corrected.
Jordan Ranch:	Mr. Wright reported he had made an on-site inspection of the Jordan Ranch proposal with the Geological Mineral Survey, State Health Department and Francis Smith, Attorney for Jordan Ranch. It appears they have problems with high water but are continuing to work on the problem.
Snake Creek Water System:	Mr. Wright reported the Snake Creek Water System has had unsatisfactory water samples the past two or three months. He sent a "boil order" letter to them this week.
Dr. Dandoy Site Visit:	Mr. Wright stated Dr. Dandoy, Executive Director of the State Health Department, is making a site visit this Thursday. The remainder of the meeting was spent in discussing issues unique to our department that would be of interest to Dr. Dandoy.

Next Meeting:	The next meeting was scheduled for Monday, July 15th at 12:00 noon in the new health offices at 805 West 100 South.
Adjourned:	Meeting was adjourned at 1:45 P.M.

_____
Vice-chairman

UTAH DEPARTMENT OF HEALTH
DIVISION OF COMMUNITY HEALTH SERVICES
BUREAU OF EPIDEMIOLOGY

Suzanne Dandoy, M.D., M.P.H.
Executive Director

COMMUNICABLE DISEASE NEWSLETTER

Adele P. Nelson, R.N., M.P.H., Director
Division of Community Health Services

EDITOR: Craig R. Nichols, M.P.A., State Epidemiologist
Director, Bureau of Epidemiology
(801) 533-6191

MONTH July YEAR 1985

CONTENTS

AIDS UPDATE

The following tables illustrate the distribution of cases of acquired immunodeficiency syndrome (AIDS) by patient groups in the United States and Utah (Table 1) and the month of reporting for Utah cases (Table 2).

While Utah accounts for only a small proportion of the total AIDS cases in the United States, patient characteristics and the rate of increase do not differ significantly from national trends. Fatality rates for the United States (50%) and Utah (53%) are also similar.

* * *

Table 1

Total Adult/Adolescent AIDS Cases By Patient Groups

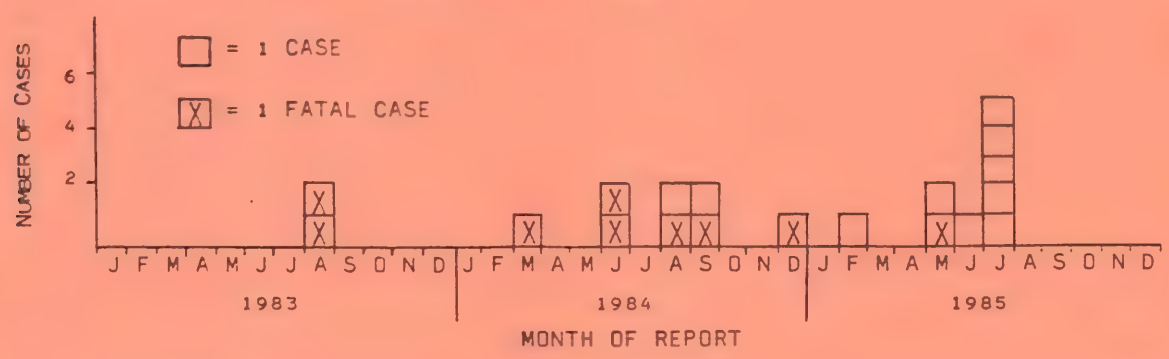
Patient Groups	U.S.[1] Cases	(%)	Utah[2] Cases	(%)
Homosexual/Bisexual Men	8,716	(73)	13	(68)
Intravenous Drug User	2,051	(17)	4	(21)
Hemophilia/Coagulation Disorder	74	(1)	0	(0)
Heterosexual Contact [To Case or At Risk]	118	(1)	0	(0)
Transfusions: Blood or Blood Products	181	(2)	2	(11)
None of the Above/Other	779	(7)	0	(0)
TOTAL	11,919	(100)	19	(100)

1 Centers for Disease Control, AIDS Weekly Surveillance Report, July 29, 1985
2 Cases reported through July 31, 1985

* * *

Table 2

AIDS Cases - Utah



TESTING DONORS OF ORGANS, TISSUES, AND SEMEN FOR ANTIBODY TO HUMAN T-LYMPHOTROPIC VIRUS TYPE III/LYMPHADENOPATHY-ASSOCIATED VIRUS[1]

The U.S. Public Health Service has recommended that all donated blood and plasma be tested for antibody to human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the virus that causes acquired immunodeficiency syndrome (AIDS). It is additionally recommended that blood or serum from donors of organs, tissues or semen intended for human use be similarly tested and that the test result be used to evaluate the appropriate use of such materials from these donors. Organs, tissues and semen obtained from HTLV-III/LAV antibody-positive persons must be considered as potentially infectious. Persons in groups having an increased risk for AIDS should not donate organs, tissues or semen, regardless of the result of the antibody test; this is the same policy currently followed for blood donations. It is recognized that the circumstances of organ procurement and the logistics of transplantation may in some instances not permit the use of an HTLV-III/LAV test. However, when feasible such testing is prudent.

1 Adapted from Centers for Disease Control Morbidity and Mortality Weekly Report, Vol. 34/No. 20, May 24, 1985.

NOTIFICATION OF HTLV-III ANTIBODY POSITIVE BLOOD DONORS[1]

Editor's Note. Blood banks in Utah have tested all inventories of blood and blood products for the presence of antibody to HTLV-III. However, donors with positive tests will not be notified until the accuracy of test results can be verified according to the following guidelines:

"Donor Notification. Ideally, donor notification should await the availability of alternative test sites. In addition, policies should be designed to avoid notification of individuals who have false positive test results, while providing notification to those in whom laboratory findings clearly indicate the presence of HTLV-III antibodies. We advise that positive results be verified by additional testing, and that, for the present, only donors whose positive test results can be verified should be notified.

"At present, there is no universally accepted confirmatory test but the Western blot is the more widely available test, and appears to be the one most frequently selected for verification. Test results may also be verified with additional ELISA testing using reagents from a different cell culture line, immunofluorescence or radioprecipitation tests. Whatever method is chosen should be carefully standardized and controlled, and be designed to stress specificity of test results.

"Donors whose blood is ELISA-positive, but negative when tested by a second method should not be notified. Their names, or other identifying information, should be entered into a 'retest' or 'surveillance' list, so that they can be readily identified at the time of any future donation. Should such donors test ELISA-negative at a subsequent donation, their blood should nevertheless be discarded and their names should remain in the 'retest' listing.

"NON-A, NON-B HEPATITIS

United States. Non-A, non-B hepatitis that presently occurs in the United States has epidemiologic characteristics similar to those of hepatitis B, occurring most commonly following blood transfusion and parenteral drug abuse. Multiple episodes of non-A, non-B hepatitis have been observed in the same individuals and may be due to different agents. Chronic hepatitis following acute non-A, non-B hepatitis infection varies in frequency from 20% to 70%. Experimental studies in chimpanzees have confirmed the existence of a carrier state, which may be present in up to 8% of the population.

"Although several studies have attempted to assess the value of prophylaxis with IG against non-A, non-B hepatitis, the results have been equivocal, and no specific recommendations can be made. However, for persons with percutaneous exposure to blood from a patient with non-A, non-B hepatitis, it may be reasonable to administer IG (0.06 ml/kg) as soon as possible after exposure.

"Epidemic (fecal-oral) non-A, non-B hepatitis. In recent years, epidemics of non-A, non-B hepatitis spread by water or close personal contact have been reported from several areas of Southeast Asia (Indian subcontinent, Burma) and north Africa. Such epidemics generally affect adults and cause unusually high mortality in pregnant women. The disease has been transmitted to experimental animals, and candidate viruses have been identified; however, no serologic tests have yet been developed.

"Epidemic non-A, non-B hepatitis has not been recognized in the United States or western Europe, and it is unknown whether the causative agent is present in these areas.

"Travelers to areas having epidemic non-A, non-B hepatitis may be at some risk of acquiring this disease by close contact or by contaminated food or water. The value of IG in preventing this infection is unknown. The best prevention of infection is to avoid potentially contaminated food or water as with hepatitis A and other enteric infections."

DIPHTHERIA, TETANUS, AND PERTUSSIS: GUIDELINES FOR VACCINE PROPHYLAXIS AND OTHER PREVENTIVE MEASURES

The Immunization Practices Advisory Committee (ACIP) has issued recommendations entitled, "Diphtheria, Tetanus, and Pertussis: Guidelines for Vaccine Prophylaxis and Other Preventive Measures" in the Morbidity and Mortality Weekly Report, Vol. 34/No. 27, July 12, 1985. This revision discusses pertussis disease and pertussis vaccine for infants and children with personal histories of convulsions or underlying neurologic disorders, as well as updating immunization schedules and recommendations. Complete copies are available from the Bureau of Epidemiology [533-6191].

STAFF CHANGES

Dorthea Lawson, Lilly Lakin, Duane Call and Kathleen Mejia are new employees in the Bureau of Epidemiology. Dorthea will serve as Immunization Program Secretary replacing Cris Chesler who is now filling the secretary position in the Communicable Disease Control Program. Lilly will serve as secretary, and Duane and Kathleen as community health specialists in the Sexually Transmitted Diseases Control Program. We welcome our new employees and send best wishes to Sharon Lovell, Mary Strong and Joseph Shaffer who have left our Bureau.

"Although their blood must not be used for transfusion, no recommendation can be made concerning the notification of donors who on repeat visits continue to show HTLV-III antibody by ELISA test only. As further information is obtained, these recommendations will be modified."

1 Adapted from American Association of Blood Banks, American Red Cross, Council of Community Blood Centers, "Joint Statement on Tests for HTLV-III Antibodies", June 7, 1985.

PERTUSSIS ALERT

As of July 31, 1985, the Utah Department of Health had received reports of 24 cases of pertussis compared to only six cases reported during the corresponding period in 1984. In 1983, 31 pertussis cases were reported in Utah, considerably more cases than had been reported in any previous year for over a decade.

Much of this year's increase is attributable to an outbreak in Davis County. Nineteen cases have been reported; three cases were laboratory confirmed by nasopharyngeal culture. All cases met the clinical criteria for diagnosis and all but two cases could be epidemiologically associated with another case. Two (10.5%) of the 19 cases occurred in infants less than six months of age, and one of these infants required hospitalization; eight (42.1%) of the cases occurred in adults. None of the children involved in the outbreak had been adequately immunized for their age.

Pertussis is a highly contagious, upper respiratory tract infection caused by Bordetella pertussis. After an incubation period commonly lasting 7-10 days, cold-like symptoms begin: coryza, sneezing, cough, and sometimes low-grade fever. The disease is most communicable when coryza appears--usually before pertussis is suspected. Atypical and asymptomatic cases probably are also involved in transmission. After about a week, the cough becomes persistent, severe and paroxysmal, sometimes followed by vomiting. In many cases, a sudden high pitched "whoop" follows the paroxysm. Young infants and adults often do not have the typical paroxysm. Over the next three to six weeks, the paroxysms gradually become less frequent, then give way to a barking cough which becomes less frequent and finally disappears altogether. Immunity from natural infection is long lasting. Infants under six months of age are at greatest risk of disease morbidity, complications and mortality.

In diagnosing pertussis, the best clue is exposure (especially household exposure) to a known case. However, the diagnosis should be considered in any child with persistent cough. All suspect and diagnosed pertussis cases should be reported to the State and county health departments.

RECOMMENDATIONS FOR PROTECTION AGAINST VIRAL HEPATITIS

The Immunization Practices Advisory Committee (ACIP) of the U.S. Public Health Service has issued updated recommendations for protection against viral hepatitis including the use of immune globulins and hepatitis B vaccine. The guidelines which were published in the Morbidity and Mortality Weekly Report, Vol. 34/No. 22, June 7, 1985, are recommended reading for all health professionals dealing with viral hepatitis. The following section is taken from the updated guidelines.

BOARD OF HEALTH AGENDA

JULY 15, 1985 12:00 PM HEALTH OFFICE

✓ALCOHOL & DRUG REPORT — caseload 16 to 19
✓IMMUNIZATION REPORT
✓WELL CHILD REPORT 12-15/mo.
✓HYPERTENSION REPORT 9
✓WIC REPORT 265 clients - State Audit 2.1/1000 — State 1.8
✓DIABETES RESEARCH — Chuck Hand
✓REPORT ON INFANT MORTALITY STUDY
✓POTTER'S MILL ORDER TO ABAATE NUISANCE
✓LONG BRANCH BAR - closed
✓BRIGHTON ESTATES REPLACEMENT OF EXISTING BUILDING — Cabin 12-15
✓SNAKE CREEK WATER SYSTEM — add 10 homes. Boil water now -
✓DANIEL DOMESTIC WATER SYSTEM — 22 July 1985 Richard to see Judge
✓JORDAN RANCH RV PARK
✓STRAWBERRY RECREATIONAL FACILITY
✓MOUNTAINLANDS CONTRACT FOR SENIOR CITIZENS
OTHER BUSINESS

✓Report from Drs as to successes.
Woodland Estates Trailers moved in
✓Homestead
✓Infant Mortality
✓Longbranch.
✓Snake Creek - Boil order
Wallsburg dead animals
Holmes Dairy drain into Lake Creek

6-25-85
From: Newborn Committee
To: Physicians caring for Newborn infants

We finally completed arrangements for Dr. Neil Kochenour and Dr. Larry Jung from the U of U to spend a day reviewing perinatal charts and discussing them with the physicians.

They will review charts on all babies who were transported, had low birth weight or had a bad outcome. We will also review some charts of babies who received other than routine care. If you are interested in discussing a particular case, let us know. We have not yet set obstetric criteria for chart reviews so I would appreciate your input.

The dates available are:

Friday Aug. 2,16 & 23
Tuesday Aug. 20
Wednesday Aug. 21

Please advise me of which date is preferable (or impossible) as soon as possible.

Drs. Jung amd Kochenour are offering us their time in an effort to help us find any problem that may be contributing to our excessive infant mortality rate, to make general suggestions on our handling of perinatal patients, and to provide continuing education to those physicians desiring it. We would appreciate your participation. Perinatal problems are by far our <u>greatest</u> liability risk.

Thanks,

Katherine S. Ferguson, M.D.

MINUTES OF THE WASATCH CITY/COUNTY BOARD OF HEALTH

July 15, 1985 12:10 P.M. Health Offices

Present were:	Connie Tatton	Vice-chairman
	R. Raymond Green, M.D.	Medical Officer
	R. C. Tadd	Commissioner
	Phil Wright	Health Officer
	Maxine McAffee, R.N.	Nurse Supervisor
	Maren Durtschi, R.N.	Nurse
	Ranae Williams, R.D.	Nutritionist/Educator
	Elizabeth Murdock	Member
	Robert Blanthorn, M.S.W.	Alcohol/Drug Director
Excused:	Calvin Giles	
	Nelda Duke	

Welcome: Mrs. Tatton welcomed those present and called the meeting to order.

Opening Prayer: The invocation was offered by Dr. Green.

Approval of Minutes: Minutes of the meeting held June 21, 1985 were read by Mrs. Durtschi. Mrs. Murdock made a motion minutes be approved as read. Mr. Tadd seconded motion. Motion carried.

Mortgage File Search: A $20 fee has been established for mortgage file search. It was felt that a maximum fee also be set. Dr. Green made a motion a maximum fee of $50 be charged for file search for sewage systems for mortgage companies. Mrs. Murdock seconded motion. Motion carried.

Alcohol/Drug Report: Mr. Blanthorn stated his new secretary is working out well. He has 16 clients but would like to have at least 19. The state contract has been approved but the Mountainlands contract is not back yet. Future plans include establishment of a helpline for information and referral to be available from 6 to 12 PM. Adults as well as adolescents would be trained to man this program. Mr. Levy will set up this program.
Mr. Blanthorn also stated his staff has been attending workshops at the University of Utah along with Beverly Prince who is working on a Federal Program for Drug Free Youth. Department funds are being used to help in this program.

School Nurse Report: Mrs. Durtschi submitted her yearly school nurse report. (See attached copy #1). Mrs. McAffee commented that when the State Auditor came that 99.1% of the J.R. Smith school were accounted for and the other schools were reported to be 100% immunized. Mrs. Durtschi should be complimented on the complete job donewith these records.

Mrs. Durtschi was asked to keep a record of the hours spent in attending workshops for the school.

Immunization Report: Mrs. McAffee reported that a state report indicates of the high risk children under 2 years of age in this County that 57.2% are not adequately immunized. The department has taken aggressive measures, sending letters and phone calls to try to get these children into the clinic.

Well Child Report: Mrs. McAffee stated we have between 12 and 15 Well Child appointments each month. Clients are rather inconsistant and break appointments frequently. Some of these children have been referred to their private physicans and handicapped children's services for further treatment. Mrs. Tatton suggested we do Well Child Outreach each 6 months in the local newspaper to make the general public aware of these services.

Hypertension Report: Mrs. McAffee reported we had only seven clients in for blood pressure checking this month. This is partly due to moving the clinic date because of the holiday.

WIC Report: Mrs. Williams reported we have 269 clients on the WIC program. We had a state audit this month and in general the program is operating very well.

Diabetes Research: It has been brought to our attention that we have a large amount of insulin sold in our county. The county incidence is 2.11% (projected 165 cases in this county). The state is 1.85% incidence.
Dr. Green stated that the number will continue to increase due to the familiar aspects of the disease. No good screening has been done in our county, now that we have a glucometer, it would be possible to screen 1,000 people and find out if we do have a high incidence.

Infant Mortality Study: Mr. Wright stated that Wasatch County has one of the highest infant mortality rates in the State. Birth-death certificates from the State have been used by a graduate class headed by Robert Parsons, BYU, they did not find any particular thing from this data, it would take $10 to $15 thousand dollars for them to do a definative study. One thing that has been developed from the study has been the pre-natal risk assessment forms for physican use in the County. The approach will be to continue to request funding from the State for Parson's to continue the research. Dr. Ferguson's letter regarding these results was read by Mr. Wright.

Potters Mill:	Mr. Wright reported that Potter's Mill was closed two years ago and transients have been living there. Zion's Bank has notified by letter that this is a public health nuisance. They have been given ten days to board it up. The attorney will be contacted if action is not taken soon then legal action will be taken. We have the authority to get it done and will bill them if necessary.
Longbranch:	Mr. Wright reported we had closed the Longbranch until sewage problems have been rectified. A new septic tank and drainfield has been installed and it looks good for reopening.
Brighton Estates:	Mr. Wright said a building in Brighton Estates had caved in from the snow and they want to replace it. They do not have water in this building. Plans are now at the building inspector's office. A septic tank or holding tank should be installed to meet code. The board supported Mr. Wright in insisting they meet code.
Snake Creek:	Snake Creek Water System has a letter from the State for them to upgrade their water system. Ten new homes can be attached to the system. They have had bad water and a boil order has been in effect the past three weeks. Their water tank in on some else's property.
Daniel Domestic Water:	Mr. Wright stated the Daniel Domestic Water System will appear before the district court for not following through on their recommendation for the water system. They haven't installed a chlorinator.
Jordan Ranch RV & Trailer Park:	Mr. Wright said the percolation test holes for the Jordan Ranch RV & Trailer Park on the West side of the road have been rejected. Mr. Jordan has dug a drain to drop the water table but engineers are not sure this will work. If he goes ahead and builds he will have a restrictive covenant where he will have to put in monitering wells or irrigate by sprinkling and at anytime if it does not meet code it could be shut down. His water supply will have to have State approval.
Strawberry Bay:	Mr. Wright reported on July5, 1985 he surveyed the Strawberry Recreation facility and found they had no power to pump the sewage. A letter was sent to the Forest Service as this is a federal project. It is not allowable not to have some kind of back up power because the sewage runs out on the ground when not pumped up the hill. Surge protectors and a back up generator is required.

Mountainland Contract:	Mr. Wright stated we will be receiving more monies from Mountainlands this next year. We need to decide what services we can offer senior citizens with these monies. It was suggested we might do screening for Adult Onset Diabetes Mellitus or maybe involve a Podiatrist.
Next Meeting;	The next meeting was scheduled for August 19, 1985 at 12:00 noon at the new building.

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Vice-chairman

UTAH DEPARTMENT OF HEALTH
DIVISION OF COMMUNITY HEALTH SERVICES
BUREAU OF EPIDEMIOLOGY

Suzanne Dandoy, M.D., M.P.H.
Executive Director

COMMUNICABLE DISEASE NEWSLETTER

Adele P. Nelson, R.N., M.P.H., Director
Division of Community Health Services

EDITOR: Craig R. Nichols, M.P.A., State Epidemiologist
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(801) 533-6191

MONTH AUGUST YEAR 1985

CONTENTS

EDUCATION AND FOSTER CARE OF CHILDREN INFECTED WITH HTLV-III[1]

The Centers for Disease Control in consultation with national experts has developed recommendations for education and care of all children known to be infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV). The following recommendations do not apply to siblings of infected children unless they are also infected.

1 case Bacterial Meningitis

"RECOMMENDATIONS

"1. Decisions regarding the type of educational and care setting for HTLV-III/LAV-infected children should be based on the behavior, neurologic development, and physical condition of the child and the expected type of interaction with others in that setting. These decisions are best made using the team approach including the child's physician, public health personnel, the child's parent or guardian, and personnel associated with the proposed care or educational setting. In each case, risks and benefits to both the infected child and to others in the setting should be weighed.

"2. For most infected school-aged children, the benefits of an unrestricted setting would outweigh the risks of their acquiring potentially harmful infections in the setting and the apparent nonexistent risk of transmission of HTLV-III/LAV. These children should be allowed to attend school and after-school day-care and to be placed in a foster home in an unrestricted setting.

"3. For the infected preschool-aged child and for some neurologically handicapped children who lack control of their body secretions or who display behavior, such as biting, and those children who have uncoverable, oozing lesions, a more restricted environment is advisable until more is known about transmission in these settings. Children infected with HTLV-III/LAV should be cared for and educated in settings that minimize exposure of other children to blood or body fluids.

"4. Care involving exposure to the infected child's body fluids and excrement, such as feeding and diaper changing, should be performed by persons who are aware of the child's HTLV-III/LAV infection and the modes

of possible transmission. In any setting involving an HTLV-III/LAV-infected person, good handwashing after exposure to blood and body fluids and before caring for another child should be observed, and gloves should be worn if open lesions are present on the caretaker's hands. Any open lesions on the infected person should also be covered.

"5. Because other infections in addition to HTLV-III/LAV can be present in blood or body fluids, all schools and day-care facilities, regardless of whether children with HTLV-III/LAV infection are attending, should adopt routine procedures for handling blood or body fluids. Soiled surfaces should be promptly cleaned with disinfectants, such as household bleach (diluted 1 part bleach to 10 parts water). Disposable towels or tissues should be used whenever possible, and mops should be rinsed in the disinfectant. Those who are cleaning should avoid exposure of open skin lesions or mucous membranes to the blood or body fluids.

"6. The hygienic practices of children with HTLV-III/LAV infection may improve as the child matures. Alternatively, the hygienic practices may deteriorate if the child's condition worsens. Evaluation to assess the need for restricted environment should be performed regularly.

"7. Physicians caring for children born to mothers with AIDS or at increased risk of acquiring HTLV-III/LAV infection should consider testing the children for evidence of HTLV-III/LAV infection for medical reasons. For example, vaccination of infected children with live virus vaccines, such as the measles-mumps-rubella vaccine (MMR), may be hazardous. These children also need to be followed closely for problems with growth and development and given prompt and aggressive therapy for infections and exposure to potentially lethal infections, such as varicella. In the event that an antiviral agent or other therapy for HTLV-III/LAV infection becomes available, these children should be considered for such therapy. Knowledge that a child is infected will allow parents and other caretakers to take precautions when exposed to the blood and body fluids of the child.

"8. Adoption and foster-care agencies should consider adding HTLV-III/LAV screening to their routine medical evaluations of children at increased risk of infection before placement in the foster or adoptive home, since these parents must make decisions regarding the medical care of the child and must consider the possible social and psychological effects on their families.

"9. Mandatory screening as a condition for school entry is not warranted based on available data.

"10. Persons involved in the care and education of HTLV-III/LAV-infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase (e.g., bleeding injury).

"11. All educational and public health departments, regardless of whether HTLV-III/LAV-infected children are involved, are strongly encouraged to inform parents, children, and educators regarding HTLV-III/LAV and its transmission. Such education would greatly assist efforts to provide the best care and education for infected children while minimizing the risk of transmission to others."

Background and references originally published with the recommendations are available on request.

1 Adapted from Centers for Disease Control Morbidity and Mortality Weekly Report, Vol. 34/No. 34, August 30, 1985.

REVISED PUBLIC HEALTH SERVICE DEFINITION OF PERSONS WHO SHOULD REFRAIN FROM DONATING BLOOD AND PLASMA[1]

Since March 1985, blood- and plasma-collection centers in the United States have used a two-phase screening procedure to decrease transmission of human T-lymphotropic virus type III (HTLV-III) through transfusion of blood or blood products. First, potential donors are informed that if they have a risk factor for AIDS they should not donate; second, the blood or plasma of persons accepted as donors is screened for antibody to HTLV-III. The low frequency of enzyme immunoassay (EIA)-positive tests among blood donors shows that the deferral criteria have been effective. Interviews with the small number of blood donors found infected with HTLV-III infection, however, have shown that most have a risk factor for HTLV-III infection; homosexual contact was the most common risk factor identified. To further reduce the risk of HTLV-III infection from blood and plasma, the U.S. Food and Drug Administration (FDA) has reworded the donor-deferral recommendations to state that any man who has had sex with another man since 1977 should not donate blood or plasma. This applies even to men who may have had only single contact and who do not consider themselves homosexual or bisexual.

1 Adapted from the Centers for Disease Control Morbidity and Mortality Weekly Report, Vol. 34/ No. 35, September 6, 1985.

PERTUSSIS UPDATE

As of August 30, 1985, a total of 40 cases of pertussis has been officially reported in Utah. This is the greatest number of cases reported in any year since 1965. Cases have been limited to four counties; Davis (19), Salt Lake (8), Utah (12), Washington (1).

Thirty-one (77.5%) of the reported cases are under six years of age with 13 cases (32.5%) being under six months of age. Nine (25.5%) of the cases required hospitalization. The average hospital stay was 3.7 days.

Many of the cases received only a ten-day course of erythromycin. To minimize antibiotic failure, cases should be treated with a 14-day course of oral erythromycin or trimethoprin/sulfamethoxazole. A 14-day course of either antibiotic should be considered also for close contacts under one year of age, regardless of immunization status, and for unimmunized close contacts under seven years. Close contacts under seven years of age who have not completed the four-dose primary series of DTP or who have not received a dose of DTP within three years of exposure should be given a dose of vaccine and should complete a primary series with the minimum intervals between doses. Some experts also recommend erythromycin prophylaxis for household contacts seven years and older.

Inadequately immunized household contacts less than seven years of age should be excluded from schools, day-care centers and public gatherings for 14 days after last exposure or until the cases and contacts have received five days of the minimum 14-day course of antibiotics.

Recommendations for Preventing Possible Transmission of Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus from Tears

Human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the etiologic agent of acquired immunodeficiency syndrome (AIDS), has been found in various body fluids, including blood, semen, and saliva. Recently, scientists at the National Institutes of Health isolated the virus from the tears of an AIDS patient (*1*). The patient, a 33-year-old woman with a history of *Pneumocystis carinii* pneumonia and disseminated *Mycobacterium avium-intracellulare* infection, had no ocular complaints, and her eye examination was normal. Of the tear samples obtained from six other patients with AIDS or related conditions, three showed equivocal culture results, and three were culture-negative.

The following precautions are judged suitable to prevent spread of HTLV-III/LAV and other microbial pathogens that might be present in tears. They do not apply to the procedures used by individuals in caring for their own lenses, since the concern is the possible virus transmission between individuals.

1. Health-care professionals performing eye examinations or other procedures involving contact with tears should wash their hands immediately after a procedure and between patients. Handwashing alone should be sufficient, but when practical and convenient, disposable gloves may be worn. The use of gloves is advisable when there are cuts, scratches, or dermatologic lesions on the hands. Use of other protective measures, such as masks, goggles, or gowns, is *not* indicated.
2. Instruments that come into direct contact with external surfaces of the eye should be wiped clean and then disinfected by: (a) a 5- to 10-minute exposure to a fresh solution of 3% hydrogen peroxide; or (b) a fresh solution containing 5,000 parts per million (mg/L) free available chlorine—a 1/10 dilution of common household bleach (sodium hypochlorite); or (c) 70% ethanol; or (d) 70% isopropanol. The device should be thoroughly rinsed in tap water and dried before reuse.
3. Contact lenses used in trial fittings should be disinfected between each fitting by one of the following regimens:
   a. Disinfection of trial hard lenses with a commercially available hydrogen peroxide contact lens disinfecting system currently approved for soft contact lenses. (Other hydrogen peroxide preparations may contain preservatives that could discolor the lenses.) Alternatively, most trial hard lenses can be treated with the standard heat disinfection regimen used for soft lenses (78-80 C [172-176 F] for 10 minutes). Practitioners should check with hard lens suppliers to ascertain which lenses can be safely heat-treated.
   b. Rigid gas permeable (RGP) trial fitting lenses can be disinfected using the above hydrogen peroxide disinfection system. RGP lenses may warp if they are heat-disinfected.
   c. Soft trial fitting lenses can be disinfected using the same hydrogen peroxide system. Some soft lenses have also been approved for heat disinfection.

Other than hydrogen peroxide, the chemical disinfectants used in standard contact lens solutions have not yet been tested for their activity against HTLV-III/LAV. Until other disinfectants are shown to be suitable for disinfecting HTLV-III/LAV, contact lenses used in the eyes of patients suspected or known to be infected with HTLV-III/LAV are most safely handled by hydrogen peroxide disinfection.

HTLV-III/LAV – Continued

The above recommendations are based on data from studies conducted at the Natior stitutes of Health and CDC on disinfection/inactivation of HTLV-III/LAV virus (*2-4*). Addi. information regarding general hospital and laboratory precautions have been previously published (*5-9*).

Reported by the U.S. Food and Drug Administration; National Institutes of Health; Centers for Disease Control.

Editorial Note: All secretions and excretions of an infected person may contain lymphocytes, host cells for HTLV-III/LAV; therefore, thorough study of these fluids might be expected to sometimes yield this virus. Despite positive cultures from a variety of body fluids of infected persons, however, spread from infected persons to household contacts who have no other identifiable risks for infection has not been documented. Furthermore, there is no evidence to date that HTLV-III/LAV has been transmitted through contact with the tears of infected individuals or through medical instruments used to examine AIDS patients.

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Reference: Centers For Disease Control Morbidity and Mortality Weekly Report, Vol. 34/No. 34, August 30, 1985.

WASATCH CITY-COUNTY HEALTH DEPARTMENT

805 WEST 100 SOUTH
HEBER CITY, UTAH 84032
PHONE (801) 654-2700

August 2, 1985

R. Raymond Green, M.D.
45 South Main
Heber City, Utah 84032

Dear Dr. Green,

Please find enclosed a copy of a letter from Dr. Cramer concerning Hib vaccine and a campaign for a vaccination program to take place during the week of September 9-16, 1985. There will be a media blitz starting the middle of August. Our local health department will not be administering the vaccine this year because of the lack of time to get necessary state and federal approvals.

If you would like to participate in this program through your clinic and would like to purchase vaccine from a central supply, you should make a determination as to how much you would need. The vaccine comes in a 10-dose vial. After a vial has been opened it is good for 30 days. There is a two-year shelf life on unopened vials.

Dr. Harry Gibbons of the Salt Lake City-County Health Department has indicated that in order to get a price break, he is willing to be the distribution point for the state. If you would like to order from him, please let him know by August 15th of the amount you need. His phone number is 530-7500.

If you have any questions, please feel free to contact me.

Thank You,

Phil D. Wright

Phil D. Wright, M.S.,R.S.
Health Officer

Encl:

July 26, 1985

Dear Colleagues,

CAMPAIGN FOR H. FLU VACCINE

Your help is needed to protect all 2-year-olds in the state of Utah from invasive H. Flu B disease. A statewide program of vaccination has been set for the week of September 9-16. The private physicians and County Health Departments have united for this important campaign. We are asking you to inform all your patients so they will be able to have the immunity against this potentially serious disease. It is hoped that all 2-year-olds are given the opportunity to receive this valuable medical product.

YOUR RESPONSIBILITY

We ask that you take aggressive and active steps to inform all parents of this disease, and the benefits of this vaccine.

COST/PRICE

We are negotiating with the distributors of the vaccine for a price break during the week of the campaign. Therefore, we are stating that the price not exceed $10.00.

DISTRIBUTING

Representatives from the pharmaceutical companies will help in the distribution to private offices.

RISKS

Enclosed is a letter on potential risks from the vaccine - as you can see they are low.

Sincerely,

Campaign for H. flu vaccine

CENTERS FOR DISEASE CONTROL

April 19, 1985 / Vol. 34 / No. 15

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Recommendation of the Immunization Practices Advisory Committee (ACIP)

Polysaccharide Vaccine for Prevention of *Haemophilus influenzae* Type b Disease

INTRODUCTION

A polysaccharide vaccine* against invasive (bacteremic) disease caused by *Haemophilus influenzae* type b recently has been licensed in the United States. The purposes of this statement are to summarize available information about this vaccine and to offer guidelines for its use in the prevention of invasive *H. influenzae* type b disease.

HAEMOPHILUS INFLUENZAE DISEASE

H. influenzae is a leading cause of serious systemic bacterial disease in the United States. It is the most common cause of bacterial meningitis, accounting for an estimated 12,000 cases annually, primarily among children under 5 years of age. The mortality rate is 5%, and neurologic sequelae are observed in as many as 25%-35% of survivors. Virtually all cases of *H. influenzae* meningitis among children are caused by strains of type b (Hib), although this capsular type represents only one of the six types known for this species. In addition to bacterial meningitis, Hib is responsible for other invasive diseases, including epiglottitis, sepsis, cellulitis, septic arthritis, osteomyelitis, pericarditis, and pneumonia. Nontypeable (noncapsulated) strains of *H. influenzae* commonly colonize the human respiratory tract and are a major cause of otitis media and respiratory mucosal infection but rarely result in bacteremic disease. Hib strains account for only 5%-10% of *H. influenzae* causing otitis media.

Several population-based studies of invasive Hib disease conducted within the last 10 years have provided estimates of the incidence of disease among children under 5 years of age, the major age group at risk. These studies have demonstrated attack rates of meningitis ranging from 51 cases per 100,000 children to 77/100,000 per year and attack rates of other invasive Hib disease varying from 24/100,000 to 75/100,000 per year (*1*). Thus, in the United States, approximately one of every 1,000 children under 5 years of age develops systemic Hib disease each year, and a child's cumulative risk of developing systemic Hib disease at some time during the first 5 years of life is about one in 200. Attack rates peak between 6 months and 1 year of age and decline thereafter. Approximately 35%-40% of Hib disease occurs among children 18 months of age or older, and 25% occurs above 24 months of age.

Incidence rates of Hib disease are increased in certain high-risk groups, such as Native Americans (both American Indians and Eskimos), blacks, individuals of lower socioeconomic status, and patients with asplenia, sickle cell disease, Hodgkin's disease, and antibody deficiency syndromes. Recent studies also have suggested that the risk of acquiring primary Hib disease for children under 5 years of age appears to be greater for those who attend day-care facilities than for those who do not (*2,3*).

*Official name: Haemophilus b Polysaccharide Vaccine.

ACIP: Haemophilus b Polysaccharide Vaccine — Continued

The potential for person-to-person transmission of systemic Hib disease among susceptible individuals has been recognized in the past decade. Studies of secondary spread of Hib disease in household contacts of index patients have shown a substantially increased risk of disease among exposed household contacts under 4 years of age (*4*). In addition, numerous clusters of cases in day-care facilities have been reported, and recent studies suggest that secondary attack rates in day-care classroom contacts of a primary case also may be increased (*5,6*).

HAEMOPHILUS b POLYSACCHARIDE VACCINE

The Hib vaccine is composed of the purified, capsular polysaccharide of *H. influenzae* type b ([—3] ribose-β1 —1 ribitol-1 phosphate-5—). Antibodies to this antigen correlate with protection against invasive disease. The Hib vaccine induces an antibody response that is directly related to the age of the recipient; infants respond infrequently and with less antibody than do older children or adults (*7*). Improved responses are observed by 18 months of age, although children 18-23 months of age do not respond as well as those 2 years of age or older. The frequency and magnitude of antibody responses reach adult levels at about 6 years of age (*8,9*). Levels of antibodies to the capsular polysaccharide also decline more rapidly in immunized infants and young children than in adults.

In a manner similar to other polysaccharide antigens, revaccination with Hib vaccine results in a level of antibody comparable to that for a child of the same age receiving a first immunization (*10*). Such polysaccharide antigens have been termed "T-cell independent" because of their failure to induce the T-cell memory response characteristic of protein antigens.

Limited data are available on the response to Hib vaccine in high-risk groups with underlying disease. By analogy to pneumococcal vaccine, patients with sickle cell disease or asplenia are likely to exhibit an immune response to the Hib vaccine. Patients with malignancies associated with immunosuppression appear to respond less well. Additional data on the immune response to Hib vaccine in these groups are needed.

A precise protective level of antibody has not been established. However, based on evidence from passive protection in the infant rat model and from experience with agammaglobulinemic children, an antibody concentration of 0.15 μg/ml correlates with protection (*7,8,11*). In the Finnish field trial, levels of capsular antibody greater than 1 μg/ml in 3-week postimmunization sera correlated with clinical protection for a minimum of 1½ years (*9,12,13*). Approximately 75% of children 18-23 months of age tested achieved a level greater than 1 μg/ml, as did 90% of 24-35 month old children (*9*). Measurement of Hib antibody levels is not routinely available, however, and determination of antibody levels following vaccination is not indicated in the usual clinical setting.

EFFECTIVENESS OF VACCINE

In 1974, a randomized, controlled trial of clinical efficacy was conducted in Finland among children 3-71 months of age (*9*). Approximately 98,000 children, half of whom received the Hib vaccine, were enrolled in the field trial and followed for a 4-year period for occurrence of Hib disease. Among children 18-71 months of age, 90% protective efficacy (95% confidence limits, 55%-98%) in prevention of all forms of invasive Hib disease was demonstrated for the 4-year follow-up period. Although no disease occurred among over 4,000 children 18-23 months of age immunized with Hib vaccine and followed for 4 years, only two cases occurred in the control vaccine recipients in this age group. As a result, vaccine efficacy in the subgroup of children immunized at 18-23 months of age could not be evaluated statistically. The vaccine was not efficacious in children under 18 months of age.

REVACCINATION

Limited data regarding the potential need for revaccination are available at present. Current

ACIP: Haemophilus b Polysaccharide Vaccine — Continued

same age. No immunologic tolerance or impairment of immune response to a subsequent dose of vaccine occurs (*10*). As with other polysaccharide vaccines, the shorter persistence of serum antibodies in young children given Hib vaccine, compared with adults, suggests that a second dose of vaccine may be needed to maintain immunity throughout the period of risk particularly for children in the youngest age group considered for vaccination (those 18-23 months of age). A second injection following the initial dose is likely to increase the protective benefit of vaccination for this high-risk group, because antibody titers 18 months after vaccination, although detectable in most vaccine recipients, are no longer significantly different from those in unvaccinated children of the same age.

RECOMMENDATIONS FOR VACCINE USE

Recently published data regarding vaccine efficacy and the risk of Hib disease among young children strongly support the use of Hib vaccine in the United States in high-risk persons for whom efficacy has been established. Specific recommendations are as follows:

1. **Immunization of all children at 24 months of age is recommended.** The precise duration of immunity conferred by a single dose of Hib vaccine at 24 months of age is not known, although, based on available data, protection is expected to last 1½-3½ years. Until further data are available to determine whether an additional dose of vaccine may be necessary to ensure long-lasting immunity, routine revaccination is not recommended.
2. **Immunization of children at 18 months of age, particularly those in known high-risk groups, may be considered.** Although the precise efficacy of the vaccine among children 18-23 months of age is not known, this age group accounts for approximately 12% of all invasive Hib disease among children under 5 years of age, and Hib vaccine has been shown by serologic methods to be immunogenic in most children of this age group. However, physicians and parents should be informed that the vaccine is not likely to be as effective in this age group as in older children. These younger children may need a second dose of vaccine within 18 months following the initial dose to ensure protection. Additional data regarding the duration of the antibody response are needed to define the timing of a second dose more precisely.

   Children who attend day-care facilities are at particular risk of acquiring systemic Hib disease. Initial vaccination at 18 months of age for this high-risk group should be considered.

   Children with chronic conditions known to be associated with increased risk for Hib disease should receive the vaccine, although only limited data on immunogenicity and clinical efficacy in this group are available. These conditions include anatomic or functional asplenia, such as sickle cell disease or splenectomy (*14*), and malignancies associated with immunosuppression (*15*).
3. **Immunization of individuals over 24 months of age who have not yet received Hib vaccine should be based on risk of disease.** The risk of invasive Hib disease decreases with increasing age over the age of 2 years. Because the vaccine is safe and effective, however, physicians may wish to immunize previously unvaccinated healthy children between 2 years and 5 years of age to prevent the Hib disease that does occur in this age group. The potential benefit of this strategy in terms of cases prevented declines with increasing age of the child at the time of vaccination. Therefore, children 2-3 years of age who attend day-care facilities should be given a higher priority than day-care attendees who are 4-5 years old.
4. **Insufficient data are available on which to base a recommendation concerning use of the vaccine in older children and adults with the chronic conditions associated with an increased risk of Hib disease.**

ACIP: Haemophilus b Polysaccharide Vaccine — Continued

6. **Simultaneous administration of Hib and DTP vaccines at separate sites can be performed, because no impairment of the immune response to the individual antigens occurs under these circumstances.**

SIDE EFFECTS AND ADVERSE REACTIONS

Polysaccharide vaccines are among the safest of all vaccine products. To date, over 60,000 doses of the Hib polysaccharide vaccine have been administered to infants and children, and several hundred doses have been given to adults (*9,16*). Only one serious systemic reaction has been reported thus far—a possible anaphylactic reaction that responded promptly to epinephrine. High fever (38.5 C [101.3 F] or higher) has been reported in fewer than 1% of Hib vaccine recipients. Mild local and febrile reactions were common, occurring in as many as half of vaccinated individuals in the Finnish trial. Such reactions appeared within 24 hours and rapidly subsided. Current preparations appear to result in fewer such local reactions. Simultaneous administration with DTP does not result in reaction rates above those expected with separate administration (*17*).

PRECAUTIONS AND CONTRAINDICATIONS

The Hib vaccine is unlikely to be of substantial benefit in preventing the occurrence of secondary cases, because children under 2 years old are at highest risk of secondary disease. Because the vaccine will not protect against nontypeable strains of *H. influenzae*, recurrent upper respiratory diseases, including otitis media and sinusitis, are not considered indications for vaccination.

NEW VACCINE DEVELOPMENT

New vaccines, such as the Hib polysaccharide-protein conjugate vaccines, are being developed and evaluated and may prove to be efficacious for children under 18 months of age.

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ACIP: Haemophilus b Polysaccharide Vaccine — Continued

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Epidemiologic Notes and Reports

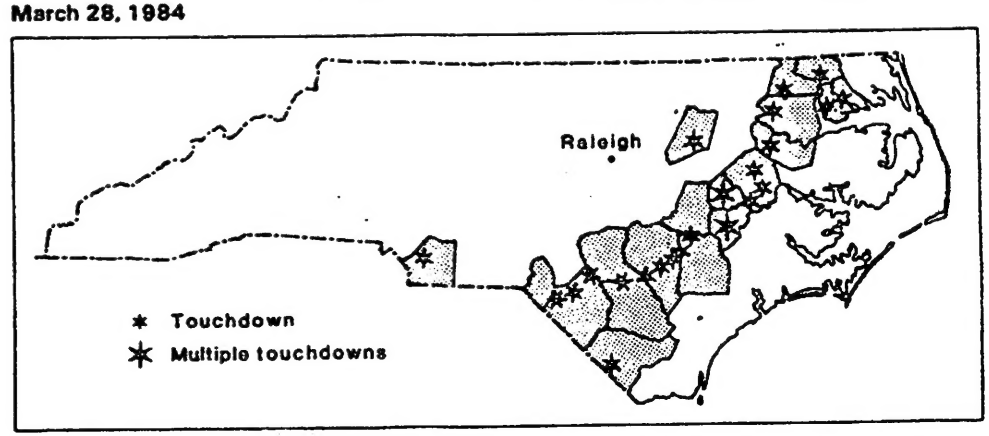
Tornado Disaster — North Carolina, South Carolina, March 28, 1984

On the evening of March 28, 1984, a series of tornadoes touched down in northeastern South Carolina and cut a swath almost exclusively through rural areas and small towns in a northeasterly direction through eastern North Carolina (Figure 1). In a 5-hour period, these storms caused more than 1,000 casualties (killed and seriously and slightly injured), along with extensive property damage of more than $100,000,000. The severity of the tornadoes varied from one to four on the Fujita scale (maximum five) and generated winds of at least 260 miles per hour.

Emergency room (ER) charts and medical records from several of the temporary first aid posts were reviewed in both North Carolina and South Carolina, and death certificates for persons with fatal injuries were analyzed. In addition, all hospitals that treated 15 or more casualties were visited and evaluated for: (1) ER treatment of these casualties; (2) "disaster drill" response of each hospital; and (3) problems that each hospital encountered in coping with the disaster.

A case was defined as an individual in either North Carolina or South Carolina who, on March 28, 1984, was injured in a tornado storm and required medical treatment. A total of

FIGURE 1. Tornado disaster, by path of storm and counties* involved — North Carolina, March 28, 1984



*The affected counties are: Bertie, Bladen, Chowan, Cumberland, Duplin, Gates, Greene, Hertford, Lenoir, Martin, Nash, Perquimans, Pitt, Robeson, Sampson, Scotland, Union, and Wayne Counties.

MINUTES OF THE WASATCH CITY/COUNTY BOARD OF HEALTH

August 19, 1985 12:10 P.M. Health Offices

Present were:	Calvin Giles	Chairman
	Elizabeth Murdock	Member
	Rulon Phillips	Member
	R. C. Tadd	Commissioner
	R. Raymond Green, M.D.	Medical Officer
	Phil D. Wright	Health Officer
	Maxine McAffee	Nurse
	Robert Blanthorn	Alcohol/Drug Director
	Nelda Duke	Secretary
Guest:	Larry Carcelli, Ph.D.	TCMHC, Phychologist

Welcome: Mr. Giles welcomed those present and called the meeting to order.

Invocation: The invocation was offered by Mr. Tadd.

TCMHC: Mr. Giles introduced Mr. Larry Carcelli who is taking Martha Hauser's position with the Timpanogos Community Mental Health Center in our county. Mr. Carcelli gave a brief background of his previous positions and stated he would like to expand services in our county. It was suggested he meet with the medical staff at the hospital and the school superintendent.

Alcohol/Drug Report: Mr. Blanthorn reported his department has been doing K-12 prevention training. They now have 4 teachers trained and will train 2 more to meet their goals. They are serving 17 clients and would like to start a women's program on communication that can be funded by a state grant. They are also planning on doing peer counseling in place of the hot line program because of insurance problems.

Immunization Report: Mrs. McAffee reported 133 immunizations were given at our last clinic. She also reported the new Hib Type B vaccine which helps prevent meningitis is now available. We will not be giving this vaccine in our department but will refer to private physicians. Mr. Wright stated we do not have authority to administer the Hib vaccine. We hope to have it within the next two to three years. Salt Lake City-County Health department is ordering the vaccine and private physicians can obtain it from them. A state wide promotion for immunizations is being planned for September.

Flu Vaccine: Mrs. McAffee reported we have received 200 doses of flu vaccine and will set up a clinic in September.

She asked what we should charge for administering the vaccine. After some discussion Mrs. Murdock made a motion we charge $4.00 per person for administering the flu vaccine. Mr. Phillips seconded the motion. Motion carried. It was suggested we keep a list of those who receive the vaccine.

Well Child Report: Mrs. McAffee reported our Well Child clinics are going very well. Ten children were seen this month. Three children have been referred for further treatment since the program began.

Blood Pressure Report: Mrs. McAffee stated there were 128 people who had their blood pressure checked at the county fair. Nine were elevated and 3 were referred to their private doctor.

WIC Report: We now have 264 clients on the WIC program and we recently had an increase in food funding.

School Health: Mrs. McAffee reported Mrs. Durtschi had attended the SNAP program. This is an educational program for school nurses and to coordinate services for the handicapped children attending school. Mr. Wright said some important legislation is coming up in school health. We will hear more on this.

Water Systems: Mr. Wright stated the Daniel Domestic Water Company was required to appear before district court. Mr. McGuire did not attend so they reset the date. The only approved systems in our county are Midway, Wallsburg and Heber. Most of the others are unapproved because of inadequate water sampling.

Tanning Beds: Mr. Wright stated we are having an influx of tanning beds in the country. People who own and operate them claim it is not dangerous. However, research shows that alot of problems can be caused through the use of these beds. A public information program is being developed in the state to warn people of problems that can develop from their use.

Indoor Clean Air Act: Mr. Wright stated the legislation is revising the Indoor Clean Air Act this year. Each business will write up their own proposals as to what they propose to do to comply with this act.

Environmental Health Funding: Mr. Wright said Dr. Dandoy will propose to the legislation to appropriate more monies for environmental health purposes. If it passes we should be able to get enough monies to hire a sanitarian.

Asbestos In Schools:	Mr. Wright stated the EPA did a study in our schools and found asbestos. The schools have corrected the problem.
Restaurant Inspections:	Mr. Wright reported the state has completed their food survey of restaurants in the state. Our county was rated third best in the state. It was suggested we try to get some help from the state to inspect each cafe in our county.
Temporary Food Permits:	Mr. Wright stated we issued several temporary food establishment permits for the county fair and it seemed to get positive results.
Open House:	Mr. Tadd stated an openhouse for our new building will be held September 4th from 2 to 5 PM.
Next Meeting:	The next meeting was scheduled for Monday, September 16th 12:00 noon in the health offices.

Meeting adjourned at 1:45 PM.

_____

Chairman